Mohamed Elsayed Khalil

Personal history:

Mohamed Elsayed Khalil, 25 y. old, student, single, from ElAbbasia, he has no habits of medical importance, rt. Handed

Complaint:

He is complaining of: weakness in lt. upper And lower limbs of 2 y. duration.

Present history:

The condition started 2 y. ago by paralysis in lt. upper and lower limbs of dramatic onset due to traumatic accident and regressive course. The paralysis was flaccid in the first 2 weeks then became spastic up till now, it affect distal more than proximal, abductors more than adductors, flexors than extensor in lower limbs and extensor than flexors in upper limbs, no wasting, fasciculation or trophic changes. There are no involuntary movements or incoordination.

At start of the condition there is loss of sensation in the rt. Side of the body to the level of the clavicle. The patient feels as he is walking on cotton on lt. side.

There is no cranial nerves affection. No sphinctiric or speech troubles, no hypothalamic manifestations, no symptoms of increase ICT, no coma, no convulsion, no fever, there is no other symptoms affection.

Past history:

No past history of medical importance.

Family history:

Family history is irrelevant

Diagnosis:

A case of spastic left side spinal Hemiplegia at level of C4 due to trauma in spastic stage.

Mahmoud Hassan Yassin

Personal history:

Mahmoud Hassan yassin, male Pt, 50 y. old, driver, from Cairo, married and has 3 children: the youngest is 10 y. old; he is heavy smoker and right handed.

Complaint:

He is complaining of weakness in the right upper and lower limbs of 2 y. duration.

Present history:

The condition started 2 y. ago in the form of sudden onset and regressive course of weakness of the right upper and lower limbs; the Ms were flaccid 6 weeks from the onset then became stiff. The weakness is distal > proximal Abd. > Add., flexors > ext. in the LL & ext. > flexors in the UL. There is no fasciculations, trophic changes, incoordination or involuntary movements. The mouth was deviated to the Lt. Side ê dribbling of saliva from the rt. side ê accumulation of food in the rt. Side. The tongue was deviated to the rt. Side and the rt. Shoulder is dropped. There is no other cranial n. affection.

There is hemi-anesthesia in the rt. Side of the body, upper and lower limbs and the face. The pt. feels as he is walking on cotton on the rt. Side. Speech problems were present in the 1st 3 Months of the disease, and then it improved.

There is no sphincteric troubles, no signs of ICT, no hypothalamic manifestations, no fever or convulsions

Past history

- The patient is suffering from DM of 2 y. duration and he is receiving oral hypoglycemic "Diamicron". Also he is hypertensive and controlled by "Capoten".

There is no history of other system affection and no operations

Family history

ê irrelevant family history.

Diagnosis:

A case of organic spastic rt. Sided capsular hemiplegia mostly due to thrombosis 2ry to hypertension

Khalid Abd Eltawwab

Personal history:

Khalid Abd Eltawwab, 44 y. old, from Helwan, employee, married 13 y. ago and has 3 children; the youngest is 3 y. old, he is moderate smoker and rt. Handed.

Complaint:

He is complaining of weakness in both LLs of 20 y. duration.

Present history:

The condition started 20 y. ago with fever and back pain. 8 days later; he went to fever hospital and had lumbar puncture. Next day he experienced flaccid paralysis and loss of sensation in both LLs and retention of urine. The flaccid paralysis became spastic after 1 month. Then he went to kasr Alainy and treated by cortisone and physiotherapy then the condition improved and he became able to walk and control his urine. The weakness affects the both LLs, distal > proximal, flexor > extensors, abductors > adductors.

No muscle wasting, trophic changes, fasciculations, involuntary movements, incoordination.

There is Hypoesthesia in both LLs to the level of T

No girdle pain, patient feels as he is walking on cotton, no cranial nerve affection, no speech affection, no sphincter troubles, no hypothalamic manifestations, and no symptoms of increase ICT, no fever, no coma, and no other system affection.

Past history:

No DM, hypertension, surgical operations

Family history: irrelevant

Diagnosis:

A case of organic spastic focal spinal paraplegia due to inflammation

Fathy Zidan

Personal history:

Fathy Zidan, 55 y. old, from Masaken Ain shams, worker, married and has 3 children; the youngest is 13 y. old, no special habits, and rt. Handed.

Complaint:

He is complaining of weakness of both lower limbs of 25 y. duration.

Present history:

The condition started 25 y. ago by trauma after falling of tree on his back. He felt with weakness of both LLs more in lt. than rt. Associated with girdle pain at the level of umbilicus. So, he admitted to Kasr Aleiny hospital and investigated by X-ray and myography but there didn't show any abnormalities. After 5 months, he admitted to neurosurgical department and investigated by exploration surgery on his back, after this operation he developed complete hemiplegia and treated by physiotherapy and vitamins. The muscles affected characterized by stiffness in both limbs distal > proximal, flexors > extensors and abductors > adductors with minimal trophic changes and normal co-ordination.

There is no muscle wasting, fasciculation or involuntary movement.

The condition is associated by Hypoesthesia below the level of umbilicus with girdle pain at the level of umbilicus but the deep and cortical sensations are intact.

There are no symptoms suggested or cranial ns affection or sphincteric troubles

Past history:

There is no fever, diabetes or hypertension, but there is a history of exploration surgery on his back.

Diagnosis:

A case of organic paraplegia due to focal extramedullary compression after trauma with sensory level to T10 in spastic stage from the start

Mohamed Elhusseiny

Personal history:

Mohamed Elhusseiny Ahmed, from Tanta, married; he has one child of 3 y. old, rt. Handed and has no special habit.

Complaint:

He is complaining of decreased sensation of 4 limbs from 16 y. ago

Present history:

The condition started 26 y. ago with polyuria, polyphagia, polydipsia and loss of weight with gradual onset and progressive course investigated by blood glucose analysis and diagnosed as diabetes type 1 treated by insulin. 10 y. later; he developed tingling and numbness in both LL with gradual onset and progressive course, then ascend to both UL taking gloves and stocks distribution, one y. later; he developed weakness of both upper and lower limbs with gradual onset and progressive course, then ascend to both UL taking gloves and stock distribution

One year later, he developed weakness of both upper & lower limbs with gradual onset and progressive course, this weakness was flaccid affecting distal more than proximal, extensors more than flexors, with mild wasting in periphery and trophic changes with no fasciculation, no involuntary movement and no in-coordination.

The Pt feels as he is walking on cotton

There is precipitancy of urine with chronic diarrhea and sweating associated with eating, he suffered from organic impotence

No cranial nerves affection, No coma, no convulsion & no increase ICT symptoms

Past history:

There is past history of laser operation for retinal hge he is hypertensive and treated by Capoten 2 yrs ago

Family history: irrelevant

Diagnosis:

A case of sensory and motor loss mainly sensory most probably Diabetic P N

Korany Adel Hashim

Personal history:

Korany Adel Hashim, 25 y. old, Does not work, from Fayuom, married and has one daughter of one y. old, no special habits, and rt. Handed.

Complaint: Weakness in four limbs of 13 y. duration

Present History:

The condition started from 13 y. ago by flaccid paresis in both upper limbs of gradual onset of progressive course. This paresis is characterized by marked wasting. No fasciculation or trophic changes. This paresis is proximal more than distal, adductor more than abductor of in both flexors and extensors.

After 5 y. the weakness appears in both lower limbs, proximal more than distal flexors and extensors, adductors and abductor the same. The flaccid paresis is characterized by marked wasting, no fasciculation or trophic changes.

No symptoms of increase I.C.T., no involuntary movement, no symptoms of cerebellar affection, no sensory affection, no speech affection, no sphincteric troubles, and no other system affection.

There are no symptoms of cranial nerves affection ***except:*** symptoms of bilateral facial nerve affection in the form of inability to close both eyes and accumulation of food behind the cheeks bilaterally.

Past history:

No history of operation, drug intake or chronic diseases.

Family history:

No similar condition of his family.

Diagnosis:

A case of pure motor neuron disease most probably Myopathy, atrophic type of facio scapilo humeral disease

Sayed Zinhum

Personal history:

Sayed Zinhum Mohamed, 43 y. old, from Hadayek elkobba, Pinter, married 16 y. ago and has 3 children; the youngest of them is 7 y. old, he is heavy smoker and rt. Handed.

Complaining:

He is complaining of weakness of 4 limbs of 5 y. duration.

Present history:

The condition started 30 y. ago, ê polyuria, polydipsia, polyphagia and loss of weight. He went to hospital and investigated by blood glucose and urine analysis and diagnosed as type 1 diabetes and treated by insulin. 10 y. later he suffered from tingling and numbness of both lower limbs then ascended to involve upper limbs, ê gradual onset and progressive course followed after 5 months by gloves and stocks of hypoesthesia, patients fell as he walking on cotton. Later he developed weakness in both upper and lower limbs, ê gradual onset and progressive course. This weakness was flaccid, hypotonia, trophic changes as brittle nails, wasting of muscles, no fascinations. It's affect LL > UL, extensor > flexor, and distal > proximal.

No involuntary movement, the patient also suffers from unsteadiness during eye closing, no cranial nerve affection, no signs of ICT, no sphinctric troubles and no speech troubles.

Past history:

There was past history and TB vertebrae

Family history: irrelevant

Diagnosis:

A case of PN motor and sensory mainly sensory most probably DM

Mohamed Mohamed Hanafy

Personal history:

Mohamed Mohamed Hanafy, 55 y. old, barber, from Ismailia, married and has 4 children; the youngest is 16 y. old, heavy smoker, and rt. Handed

Complaint:

Difficulty in walking and talking of 36 y. duration

Present history:

The condition started 36 y. ago by gradual onset and progressive course of gait disturbance, difficulty in speech and kinetic irregular tremors in both hands and feel, increased with emotional stress and decreased with sleep.

The patient started to suffer from precipitancy of urine.

There is no symptoms suggesting increased ICT, no symptoms suggesting sensory affection, no symptoms suggesting cranial nerves affection , no hypothalamic manifestations

There is no symptoms suggesting other systems affection

Past history:

There is no past history of D.M., HTN, fever, trauma, operation

There is history of drug intake.

Family history: irrelevant

Diagnosis:

Bilateral UMNL and cerebellar lesion most probably herdofamilial ataxia, most probably Marie's ataxia

Mohamed Tawfiq Mohamed

Personal history:

Mohamed Tawfiq Mohamed, 35 y. old, he works at factory, smoking 20 cigarettes per day for 15 y., and rt. Handed.

Complaint:

Weakness of four limbs of 5 y. duration

Present history:

The patient was completely normal since 5 y. when he started to complain of numbness & tingling. The weakness starts in the Rt. side of the body of sudden onset and remittent course, spastic from the start, no wasting, no fasciculation and no trophic changes. Distal > proximal, abductor > Adductor, extensor than flexor of LL then the patient went to Kasr Elainy hospital and investigated with MRI & treated by cortisone, then he recovered but not completely.

The weakness repeated with the same character and distribution but involves the left side of the body.

He also complains of tremors of sudden onset, remittent course more with movement, irregular with muscle stiffness, Rt >Lt, distal > proximal associated with trunkal tremors.

There is also loss of coordination.

He also complains of diminution of vision, accumulation of food of both sides of mouth, drilling of saliva of both sides of mouth, excessive lacrimation, no nasal tone of voice, nasal regurgitation, difficulty of swallowing, and frequent shocking.

There is also abnormality of speech, and precipitancy of urine

There are no symptoms suggestive of ICT, no symptoms suggestive of sensory affection,

There are no symptoms suggestive of other system affection

Past history:

No past history of diabetes, hypertension, drugs and operation

Family history: Irrelevant

Diagnosis:

A case of organic disseminated neurological disorder, most probably multiple sclerosis.

Ramadan Mohamed Elsayed

Personal history:

Ramadan Mohamed Elsayed, driver, married and has 2 children; the youngest is 5 y. old, heavy smoker, and Rt. Handed.

Complaint:

He is complaining of weakness in both four limbs for 20 y. duration.

Present history:

The condition started by weakness on Rt. Hand for y. duration, after 2mo weakness on Rt. Foot, the Lt. hand and Lt. foot by gradual onset and progressive course

The weakness affected distal > proximal, abductor > adductor, extensor > flexor in upper limb, and flexor > extensor in lower limb

There are fasciculations, wasting, flaccidity of muscles and no sensory affection.

No symptoms of increase ICT affection, no sphincteric, no symptoms of cranial nerves affection, no convulsion, no fever, no hypothalamic manifestation, and no sphincteric trouble

Past history:

No past history of DM, HTN, TB, major operation, or drug intake

Family history: irrelevant

Diagnosis:

A case of MND; spinal type; mixed type (amyotrophic lateral sclerosis)